

For Office Use Only:

elationship Beyon		PF000735602		Scrutiny No. For Agent Use Onl		pt No.	Policy No.
Emp/LG Code	Loan Account Number	Intermediary Code	Sub Intermediary Code	Intermediary N	ediary Name		bile No.

HEALTH CARE SUPREME INDIVIDUAL POLICY - PROPOSAL FORM

INSTRUCTIONS FOR FILLING UP THE FORM

1. Please answer all questions in BLOCK letters 2.

- The Liability of the Company does not commence until this Proposal has been accepted by the Company and premium has been paid
- This Proposal will be the basis of any subsequent policy that we issue to you. It is therefore essential that you provide all the information in this Proposal FULLY AND 3. ACCURATELY and that you provide us with any and all additional information relevant to risk to be insured or our decision as to acceptance of the risk or the terms upon which it should be accepted

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PROPOSER DETAILS										
1) Full Name Title										
2) Are you an existing Bajaj Allianz Customer: Yes / No If yes, please mention the Policy No: OG										
3) Gender: Male Female 4) Date of Birth D M M Y Y 5) PAN No.										
6) UID/Unique ID										
8) Marital Status Married Single Divorced Widowed 9) No. of Children Sons: Daughters:										
10) Occupation Business Salaried Professional Student House Wife Others										
11 A) PERMANENT / RESIDENTIAL ADDRESS 11 B) CORRESPONDENCE ADDRESS: (All the communications will be sent to the below address)										
House No. House House No. House House House House										
Landmark/ Locality										
Road/ Area Name										
City/District										
State Pin Code State Pin Code										
Tel. Tel.(Res.) Tel.(Res.)										
Mobile Tel.(Office) Tel.(Office)										
Email Mobile Number										
E-Mail										
12) Educational Qualification: Matriculate Under Graduate Graduate Post Graduate Professionally Qualified										
13) Family Monthly Income: Up to ₹20,000										
14) In case of any Offer, you would prefer to be contacted by: Phone Email 15)Nationality										
Medical Expenses Section :- Details of the persons to be insured										
Sr Name DOB Age Gender Ht Wt Occupation Relation Nominee Relationship										

No	Name	(dd/mm/yy)	Age	(M/F)	Ht	Wt	Occupation	Relation	Nominee	of Nominee

16) Period of Insurance: From D D M M Y Y Y Y TO D D M

Add On Covers - Optional (please tick option opted for and mention sum insured in table given below)

- Ancillary Expenses Benefit Section:a.
- b. Critical Illness:-

Personal Accident:c.

Yes No Yes No Yes No Sum Insured Table:

Sr No.	Name	Hospitalisation Section	Ancillary Expenses	Critical Illness	Personal Accident*

*For dependent family members the maximum Sum Insured under Personal Accident would be ₹ 5 lacs.

17) Do you have any other Health policy/policies, Personal Accident Policy/policies (with us or any other insurer) if yes, please provide the details in the below table. If opting for portability, please fill the portability annexure

		Details of previous		Period o	First policy	
Name of Insured	Name of Insurance Company	health insurance policy / policies no	Sum Insured	From MM/DD/YY	To MM/DD/YY	inception date

18) Medical history:-

Questions	Yes / No
During the last 4yrs and before 4yrs, have any of the proposed insured consulted any physician for treatment or medical investigation or surgical operation, Accident or been hospitalized for any disorder?	
Have any of the proposed insured's ever been diagnosed with or advised to seek treatment for any one or more from the following: heart disease, Diabetes/ raised blood sugar, High blood pressure/ Hypertension, Circulatory disease?	
Paralysis, cancer, Disease of kidney, Liver, Stomach, Intestine, brain, Lung or joint disorder, mental illness, Congenital/ Birth defect ,Physical deformity, or HIV/AIDS	
Disorders of eye, ear, nose or throat, Gland disorder such as thyroid, Blood disorder or disorder of reproductive or urinary system	
Any other illness, impairment, disability or surgery not mentioned above?	
Have any of the proposed insured's Parents, brothers or sisters had heart disorders, cancer, Diabetes, neurogical or mental disorder, hereditary or chronic disorder?	
Is any of the proposed insured currently taking any medication/ treatment for any disease or disorder?	
Is any of the proposed insured currently pregnant?	
Have any of the proposed insured proposal or application for reinstatement of life, health and accident insurance ever been declined, postponed, withdrawn or accepted with modified terms by any insurance company?	
9) Additional information:- If you have answered yes in any of the above questions please furnish details:-	

Sr No	Name of the proposed insured	Please specify the illness details with symptoms	Treatment details with treating Doctor details	Outcome of treatment (e.g. Ongoing, complete recovery, recurrent or likely to recur)

20) Does any person proposed to be insured smoke or consume tobacco, alcohol or any other form of Tobacco? Yes 📃 No 📃

*DECLARATION

- 1. I hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge and that I am authorised to propose on behalf of these other persons.
- 2. I understand that the information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurer and that the policy will come into force only after full payment of the premium chargeable.
- 3. I further declare that I will notify in writing any change occurring in the occupation or general health of the life to be insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the company.
- 4. I declare that I consent to the company seeking medical information from any doctor or hospital who/which at any time has attended on the person to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured /proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
- 5. I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory authority.

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D/MM/YYYY	Date:	D	D	М	Μ	Y	Y	Y	Y	

Signature of Proposer

INSURANCE ACT, 1938 SECTION 41 - PROHIBITION OF REBATES

Proposed Policy Period: From: DD/MM/YYYY, To: D

No person shall allow or offer to allow either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurer. ANY PERSON MAKING FAULT IN COMPLYING WITH THE PROVISIONS OF THIS SECTION SHALL BE PUNISHABLE WITH FINE WHICH MAY EXTEND TO RUPEES TEN LAKH. * Please read declaration wordings carefully before signing the proposal form.

> Bajaj Allianz General Insurance Co. Ltd | G.E. Plaza, Airport Road, Yerawada, Pune - 411006. IRDA Reg No.: 113. Website: www.bajajallianz.com | Call: 1800-209-0144/1800-209-5858 | CIN: U66010PN2000PLC015329 | E-mail: customercare@bajajallianz.co.in